Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Donald Wehmeyer, MD

Respondent Name
Liberty Mutual Fire Insurance

MFDR Tracking Number
M4-15-1071-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 5, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I wish to file a formal dispute resolution for services rendered…for an impairment rating. This was carried out on 14 July 2014. [Injured employee] was referred to me by Dr. Christine Wan to carry out an impairment evaluation...

I billed the insurance carrier $1250.00 for the service…I received an Explanation of Benefits, date of audit 8 August 2014, in which the insurance company decreased the payment by $300.00…On 11 September 2014 I called the insurance company…and she was going to send the bill back for review and said it would take ten working days. I received another Explanation of Benefits for audit date 17 September 2014, in which no additional payment was sent…At this point, I wrote a letter dated 27 October 2014 and mailed 30 October 2014…Along with that letter, I sent the original Explanation of Benefits, audit date 8 August 2014 and the Explanation of Benefits audit date 17 September 2014, and a HCFA-1500 marked Request for Reconsideration, …as well as a copy of my letter of 23 July 2014. These have been further to identify and elucidate the CPT code with the charge billed…I received another Explanation of Benefits, audit date 12 November 2014, again saying that they were not going to allot any further funds…

The claimant had five ratable areas…the insurance company was correct that ribs are considered part of the spinal column, however, the lungs are not part of the spinal column…This particular individual had the injuries to: 1. Shoulder (upper extremity). 2. Fractured hip (lower extremity). 3. Cervical spine (spine). 4. Concussion. 5. Lung contusion. As best as I can tell, the insurance company has not paid for the concussion or the lung contusion…"

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have reviewed the reimbursement issued for services of 7/14/14 and have determined that no additional reimbursement is necessary. According to the Medical Fee Guidelines a maximum of three musculoskeletal body areas (units) may be billed. It appears that the provider is billing for body parts and not for body areas as defined by the Division.

The three musculoskeletal body areas are:
Spine and pelvis
Upper extremities and hands
Lower extremities and hands

The provider was reimbursed for the three allowed body areas."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 14, 2014	99456 WP	$300.00	$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.124 sets out the guidelines for determining a valid impairment rating.
3. 28 Texas Administrative Code §130.1 sets out the procedures health care providers must follow to determine maximum medical improvement and impairment ratings.
4. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Division-specific services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.
   - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the correct MAR for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the requestor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is $350.00.

   This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4), which states that "(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) **spine and pelvis**; (II) **upper extremities and hands**; and, (III) **lower extremities (including feet)**. (ii) The MAR for musculoskeletal body areas shall be as follows (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area. (D) …(i) Non-musculoskeletal body areas are defined as follows: (I) **body systems**; (II) body structures (including skin); and, (III) mental and behavioral disorders. (ii) **For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides**… (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150" [emphasis added].

   Review of the submitted documentation finds that the requestor performed impairment rating evaluations of the right shoulder (with range of motion), the left hip (with range of motion), the cervical spine, concussion, and the ribs/lungs. The AMA Guides to the Evaluation of Permanent Impairment (fourth edition) places the ribs and lungs in the Respiratory System and the concussion is rated under the Nervous System. For this reason, both are considered body systems in the non-musculoskeletal category. Therefore the total MAR for this examination is $900.00.

   The total MAR for billed CPT Code 99456 WP is $1250.00. See the table below for a detailed analysis.

Examination	§134.204 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]	$350.00
IR: Right shoulder (ROM)	Upper Extremities	$300.00
IR: Left hip (ROM)	Lower Extremities	$150.00
IR: Cervical spine (DRE)	Spine/Pelvis	$150.00
IR: Concussion	Body Systems	$150.00
IR: Ribs/lungs	Body Systems	$150.00
Total MMI	[redacted]	**$350.00**
Total IR		**$900.00**
Total Exam		**$1,250.00**

2. Review of the submitted documentation finds that the requestor billed $1250.00 for CPT Code 99456 WP. The total allowable is $1250.00. The insurance company paid $950.00. Therefore, the requestor is entitled to an additional reimbursement of $300.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	April 9, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.